

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14685

CERTIFICATE OF DEATH

14688

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtoun</u> | | | c. LENGTH OF STAY IN 1b <u>115 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Drayden</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u> | | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Margaret</u> Last <u>Adams</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1966</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1896</u> | | 9. AGE (In years last birthday) yrs. <u>70</u> | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George R. Watts</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Meakin</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Richard B. Adams</u> | | Address <u>Drayden, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO (b) <u>Valvular heart disease (aortic regurgitation)</u> stating the underlying cause last. (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1966</u> , to <u>Oct 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 13 1966</u> , and that death occurred at <u>11 A</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>P.J. Bear</u> | | | | 22b. DATE SIGNED <u>Oct 16/66</u> | | 22c. PHYSICIAN'S NAME (Type) <u>P.J. Bear, M.D.</u> | |
| 22d. ADDRESS <u>Great Mills, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 17, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Georges Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Valley Lee, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtoun, Maryland</u> | | | | 25a. REC'D BY REGISTRAR <u>OCT 18 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14686

CERTIFICATE OF DEATH

14689

| | | | |
|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HELEN JOY BOWLING | | 4. DATE OF DEATH Month OCT. Day 5 Year 19 66 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/15/1886 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. BIRTHPLACE (County & State, or foreign country) MARYLAND | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME GEORGE W. JOY SR. | | 14. MOTHER'S MAIDEN NAME KATHERINE BLACKMAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216 12 4710D | |
| 17. INFORMANT ETHEL JOY - LEONARDTOWN, MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dilatation of Heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Edema of Lungs DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 10, 1966 , to OCT 5, 1966 that (I) (we) last saw the deceased alive on OCT 5, 1966 and that death occurred at 5 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles Greenwell | | 22b. DATE SIGNED 10/7/66 | |
| 22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D. | | 22d. ADDRESS LEONARDTOWN, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/8/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEM. | | 23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, MD. | |
| 24. FUNERAL DIRECTOR John M. Welch | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE John M. Welch - LEONARDTOWN, MD. | | DATE OCT 11 1966 | |

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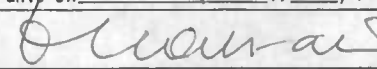
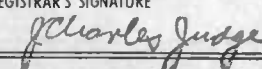
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14687

CERTIFICATE OF DEATH

14690

| | | | | | | | |
|---|---|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS NURSING HOME | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ELVA Middle BLANCHE Last COBUN | | | | 4. DATE OF DEATH Month OCTOBER Day 29 Year 19 66 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 3/19/1889 | | 9. AGE (In years last birthday) yrs. 77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC | | 11. BIRTHPLACE (County & State, or foreign country) BUTLER CO. PENNA. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN E. COBUN | | | | 14. MOTHER'S MAIDEN NAME JENNY WARD | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217 28 8345D | | 17. INFORMANT Address MISS NINA M. COBUN - LEONARDTOWN, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4201 DUE TO coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of hip (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, Stenosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-28-66, 19 to Oct 29, 1966, that (I) (we) last saw the deceased alive on Oct 28, 1966, and that death occurred at 8 P. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE  | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) MICHAEL BARBARICH M.D. | |
| 22d. ADDRESS LEONARDTOWN - LEONARDTOWN MARYLAND | | 22e. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 11/2/66 | 23c. NAME OF CEMETERY OR CREMATORY CHARTIERS CEMETERY | | 23d. LOCATION (City or Town) (County) (State) CARNEGIE, PENNA. | | |
| 24. FUNERAL DIRECTOR J. M. Welch - LEONARDTOWN, MARYLAND | | | | 25a. REC'D BY REGISTRAR DATE NOV 3 1966 | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14688

CERTIFICATE OF DEATH

14691

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - HOLLYWOOD 181 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle ELLA Last CURTIS | | 4. DATE OF DEATH Month OCT. Day 9 Year 1966 | |
| 5. SEX FEMALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/5/1918 |
| 9. AGE (In years last birthday) 48 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME GEORGE BOWMAN | | 14. MOTHER'S MAIDEN NAME LINETTE MASON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212 24 4779 | |
| 17. INFORMANT J. ALBERT CURTIS - LEONARDTOWN, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Cardio Vascular DUE TO (c) 10 yrs | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 25, 1958 , to Oct 9, 1966 , that (I) (we) last saw the deceased alive on Oct 8, 1966 , and that death occurred at 440 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>W.D. Boyd</i> | | 22b. DATE SIGNED 10/10/66 | |
| 22c. PHYSICIAN'S NAME (Type) WM.D. BOYD M.D. | | 22d. ADDRESS LEONARDTOWN, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 10/12/66 | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEM. | 23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, MD. |
| 24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR DATE OCT 13 1966 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14689

CERTIFICATE OF DEATH

14692

| | | | | | |
|---|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u> | | c. LENGTH OF STAY IN 1b <u>18 years</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan Ficklin Fowler</u> | | | 4. DATE OF DEATH Month Day Year <u>October 22, 19 66</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>July 5, 1913</u> | | 9. AGE (In years last birthday) yrs. <u>53</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Gene Ficklin</u> | | | 14. MOTHER'S MAIDEN NAME <u>Edith V. Javins</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address <u>Henry J. Fowler Mechanicsville, Maryland</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma bile ducts</u> 1551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July, 1955</u> , to <u>Oct, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 21, 1966</u> and that death occurred at <u>3:15 A</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Leon W B Berube</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Leon W B Berube MD</u> | | 22d. ADDRESS <u>Mechanicsville, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct. 25, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Morganza, Maryland</u> | | |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u> | | | 25a. RECD BY REGISTRAR DATE <u>OCT 27 1966</u> | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 14690 | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | 14693 | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tall Timbers</u> | | | c. LENGTH OF STAY IN 1b <u>Life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tall Timbers</u> | | | | | 18-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Gwynn</u> Middle <u>Bryan</u> Last <u>Fox</u> | | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>19 66</u> | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 25, 1914</u> | | 9. AGE (In years last birthday) <u>52</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | |
| 13. FATHER'S NAME <u>James Brooke Bryant</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Oldham Rooker</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Brooke Bryant Tall Timbers, Maryland</u> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> <u>4331</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>3 years</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Noturol causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>W.D. Boyd M.D.</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22. DATE SIGNED <u>10/24/66</u> | | | | | | |
| EXAMINER'S NAME (Type) <u>William D. Boyd M. D.</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 23, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. George Episcopal</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Valley Lee, Maryland</u> | | | | | | |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>OCT 25 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14694

| | | | | | | | |
|--|----------------------------------|---|--|---|---------------------------|---|---------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i> | | c. LENGTH OF STAY IN 1b <i>DOA</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hollywood</i> | | 18-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Elmer</i> Last <i>Guy</i> | | | | 4. DATE OF DEATH Month <i>October</i> Day <i>15</i> Year <i>1966</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 21, 1897</i> | 9. AGE (In years less birthday) <i>68</i> yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William Guy</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Lucy Downs</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>217-09-1953A</i> | | 17. INFORMANT <i>Mrs Alberta G. Heard</i> | | Address <i>Hollywood, Maryland</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of skull and</i> <i>8124</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Multiple severe injuries (struck by auto)</i> (c) <i>Interval between onset and death</i> <i>Immediate</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by auto while crossing Route 255</i> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>8:30</i> p.m. <i>Oct 15 1966</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>Highway (Route 255)</i> | | 20f. (City or town) (County) (State) <i>Hollywood, St. Mary's Md</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>P. J. Bear M. D.</i> | | EXAMINER'S NAME (Type) <i>P. J. Bear M. D.</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED <i>10/16/66</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Oct. 18, 1966</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Hollywood, Maryland</i> | |
| 24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>OCT 18 1966</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

EXAMINER'S
NAME (Type)

230. BURIAL, CREMATION,

24. FUNERAL DIRECTOR

W. Clarke Mattingley Leonardtown, Maryland

14692

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14695

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY | | St. Mary's MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| Leonardtoun | | D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? | |
| St. Mary's Hospital | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | 4. OATE OF DEATH | |
| First Middle Last Joseph Franklin Guy | | Month Day Year October 28, 1966 | |
| 5. SEX | | 6. COLOR OR RACE | |
| Male | | White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | May 27, 1918 | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR Months Days | |
| 48 | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| Farming & Carpenter | | Medley's Neck, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| George F. Guy | | Mary Ellen Turner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | | |
| 17. INFORMANT Address | | Joyce Norris Guy Great Mills, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH | |
| (a) IMMEDIATE CAUSE (a) 4201 | | summed | |
| (b) OUT TO | | | |
| (c) OUT TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED | |
| ACTUAL SIGNATURE William D. Boyd, M.D. | | 10/29/66 | |
| EXAMINER'S NAME (Type) William D. Boyd, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 31, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery | | 23d. LOCATION (City or Town) (County) (State) Great Mills, Maryland | |
| 24. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR OCT 31 1966 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE | |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|---|--|--|
| 14693 | | | | | 14696 | | | | |
| 1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown | | | c. LENGTH OF STAY IN 1b 32 Minutes | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Great Mills | | | 18.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Saint Mary's Hospital | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Knott | | | 4. DATE OF DEATH Month Day Year October 9 1966 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-9-66 | | 9. AGE (In years last birthday) yrs. 32 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country) St. Mary's Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Benjamin Alfred Knott | | | | | 14. MOTHER'S MAIDEN NAME Margaret Sandra Forrest | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 7511 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Very difficult delivery DUE TO (b) Hydrocephalus, Meningocele DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 min | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/9 , 19 66 to 10/9 , 19 66 , that (I) (we) last saw the deceased alive on 10/9 , 19 66 and that death occurred at M , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE James P. Jarboe M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 10/10/66 | | |
| 22c. PHYSICIAN'S NAME (Type) James P. Jarboe M.D. | | | 22d. ADDRESS Great Mills, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) Buried, 1966 | | | 23b. DATE THEREOF Oct. 10, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Georges | | 23d. LOCATION (City, town or county) (State) Valley Lee, Maryland | | |
| 24. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Md. | | | | | 25a. REC'D BY REGISTRAR 13 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

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5.2021

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14694

14697

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> | | c. LENGTH OF STAY IN lb <u>120 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chaptico</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's County Nursing Home</u> | | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harry</u> Last <u>Knott</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 22, 1898</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>66</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>James W. Knott</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Eleanor Nelson</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Alice E. Knott Chaptico, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smothering</u> DUE TO (b) <u>Hypernephroma Rt Kidney</u> DUE TO (c) <u>180x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u> <u>1 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Artery Sclerosis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Oct</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 3</u> 19 <u>66</u> , and that death occurred at <u>10-5-66</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>David Mossman M.D.</u> | | 22b. DATE SIGNED <u>10-5-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>David Mossman M.D.</u> | | 22d. ADDRESS <u>Machanicsville, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>10/6/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Chaptico, Md.</u> | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>OCT 10 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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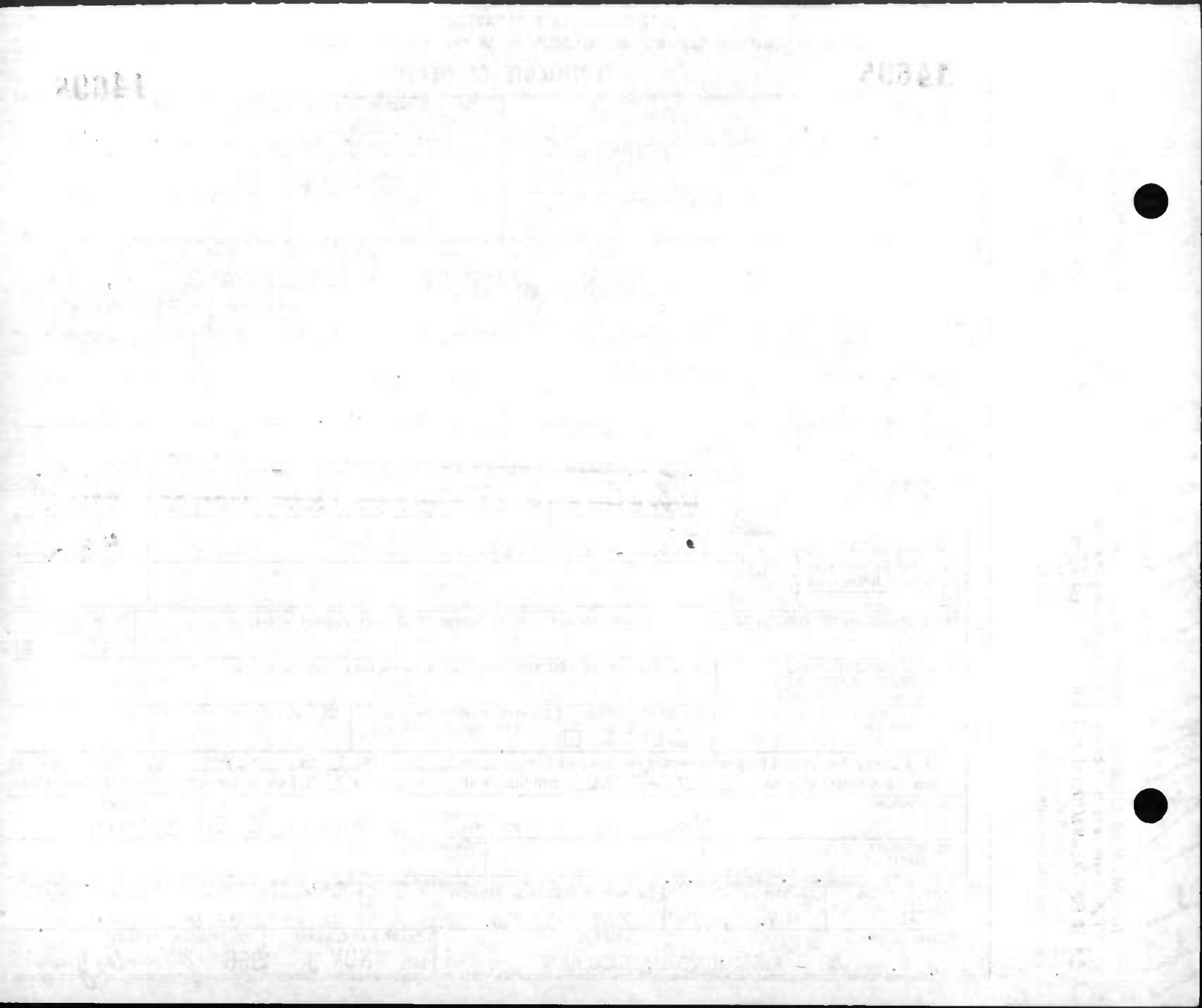
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|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ADA MARIA LAWRENCE | | | 4. DATE OF DEATH Month Day Year OCTOBER 29, 19 66 | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/10/1901 | 9. AGE (In years lost birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER | | |
| 10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC | | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME WILLIE BROOKS | | | 14. MOTHER'S MAIDEN NAME NELLIE MILLS | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218 30 7978 | 17. INFORMANT Address EDITH MARIE LAWRENCE - LEXINGTON PARK, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Heart Disease (Initial Artery) (c) Arteriosclerosis DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 years | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | 21. I certify that (I) (this hospital) attended the deceased from November 1962 , to Oct 1966 , that (I) (we) last saw the deceased alive on Oct 27 1966 , and that death occurred at 4:15 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE P. J. BEAN M.D. | | | 22b. DATE SIGNED 10/31/66 | | 22c. PHYSICIAN'S NAME (Type) P. J. BEAN M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF NOV. 2, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY | | |
| 23d. LOCATION (City or Town) (County) (State) GREAT MILLS ST. MARY'S MD. | | | 24. FUNERAL DIRECTOR ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND | | | | |
| 25a. REC'D BY REGISTRAR NOV 3 1966 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20021

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If *any* delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY in lb 15 min. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle E. Last MASON | | 4. DATE OF DEATH Month 10 Day 25 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 4, 1925 |
| 9. AGE (In years last birthday) 41 yrs. | | 10. IF UNDER 1 YEAR Months 10 Days 25 Hours 19 Min. 66 | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (State or foreign country) Maryland | | 13. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. FATHER'S NAME James A. Mason | | 15. MOTHER'S MAIDEN NAME Mary Alice Mason | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 11 | |
| 18. INFORMANT Lottie Mason | | 19. Address Callaway, Maryland | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and purulent bronchitis DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Fatty alteration of Liver | | 21. INTERVAL BETWEEN ONSET AND DEATH | |
| 22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fatty alteration of Liver | | 23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 24a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Partial | |
| 26. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 29. (City or town) (County) (State) | |
| 30. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | |
| 32. ACTUAL SIGNATURE Werner U. Spitz | | 33. DATE SIGNED 10/26/66 | |
| 34a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 35b. DATE THEREOF Oct. 29, 1966 | |
| 36c. NAME OF CEMETERY OR CREMATORY St. George Cemetery | | 37d. LOCATION (City or Town) (County) (State) Valley Lee, Maryland | |
| 38. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland | | 39. REC'D BY REGISTRAR OCT 28 1966 | |
| 40. REGISTRAR'S SIGNATURE Charles Judge | | 41. REGISTRAR'S SIGNATURE | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14697

CERTIFICATE OF DEATH

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|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>Rt. 1 Box 99</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Margaret</u> Last <u>Miedzinski</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 30, 1926</u> |
| 9. AGE (in years last birthday) <u>39</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Daniel Webster Lacey</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances Virginia Hill</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Thomas Miedzinski</u> | | Address <u>same as # 2 above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>10/19</u> Hour <u>11:30</u> a.m. <u>1966</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>Oct</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug</u> , 19 <u>66</u> , and that death occurred at <u>11 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Leon Berube</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Leon Berube M.D.</u> | | 22d. ADDRESS <u>Mechanicsville, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct. 22, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Hollywood, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 26 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14698

CERTIFICATE OF DEATH

14701

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|--|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> | | | c. LENGTH OF STAY IN 1b <u>20 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> | | | 18-1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u> | | | | d. STREET ADDRESS <u>Rt. 1 Box 29</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lizzie</u> Middle <u>Mae</u> Last <u>Milstead</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1966</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 25, 1877</u> | | 9. AGE (In years last birthday) yrs. <u>88</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Thomas P. Simmons</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marion Frances Bowie</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Marion M. Stevens</u> Address <u>same as # 2 above</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathroom</u> | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m. Sept 7 1966</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Lexington Park St. Mary's Md</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1966</u> , to <u>Oct 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 30, 1966</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>R. V. BEAN</u> | | | | 22b. DATE SIGNED <u>Oct 3/66</u> | | 22c. PHYSICIAN'S NAME (Type) <u>R. V. BEAN</u> | |
| 22d. ADDRESS <u>Great Mills, Md</u> | | | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 4, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Baptist Church</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Nanjemoy Maryland</u> | | 23e. REC'D BY REGISTRAR <u> </u> |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u> | | | | | 25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14699

CERTIFICATE OF DEATH

14702

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <i>St. Mary's</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland.</i> b. COUNTY <i>St. Mary's</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i> | | | c. LENGTH OF STAY IN 1b <i>4 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mechanicville</i> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i> | | | | d. STREET ADDRESS | | | 18-1 |
| 3. NAME OF DECEASED (Type or print) First <i>Cora</i> Middle <i>Elizabeth</i> Last <i>Morgan</i> | | | | 4. DATE OF DEATH Month <i>October</i> Day <i>28</i> Year <i>1966</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 8, 1886</i> | | 9. AGE (In years last birthday) <i>80</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <i>St. Mary's Co.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John W. Tippet</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Abbie Van Wert</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs. Martin Pilkerton</i> | | Address <i>Mechanicville.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Atherosclerotic Cardiovascular</i> (c) <i>20 yr</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 1948, to <i>Oct 28</i> , 1966, that (I) (we) last saw the deceased alive on <i>Oct 27</i> , and that death occurred at <i>7 AM</i> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>J. Roy Guyther</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <i>J. Roy Guyther, M.D.</i> | | | | 22d. ADDRESS <i>Mechanicville, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>10/31/66</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Bushwood, St. Mary's Md.</i> | |
| 24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i> | | | | ADDRESS <i>Leonardtown Md.</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

14710

CERTIFICATE OF STATE

14680

1. Name

2. Address

3. Occupation

4. Date of birth

5. Date of death

6. Place of birth

7. Place of death

8. Cause of death

9. Date of burial

10. Place of burial

11. Date of cremation

12. Place of cremation

13. Date of interment

14. Place of interment

15. Date of exhumation

16. Place of exhumation

17. Date of reinterment

18. Place of reinterment

19. Date of removal

20. Place of removal

21. Date of return

22. Place of return

23. Date of disposal

24. Place of disposal

25. Date of final disposition

26. Place of final disposition

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14700

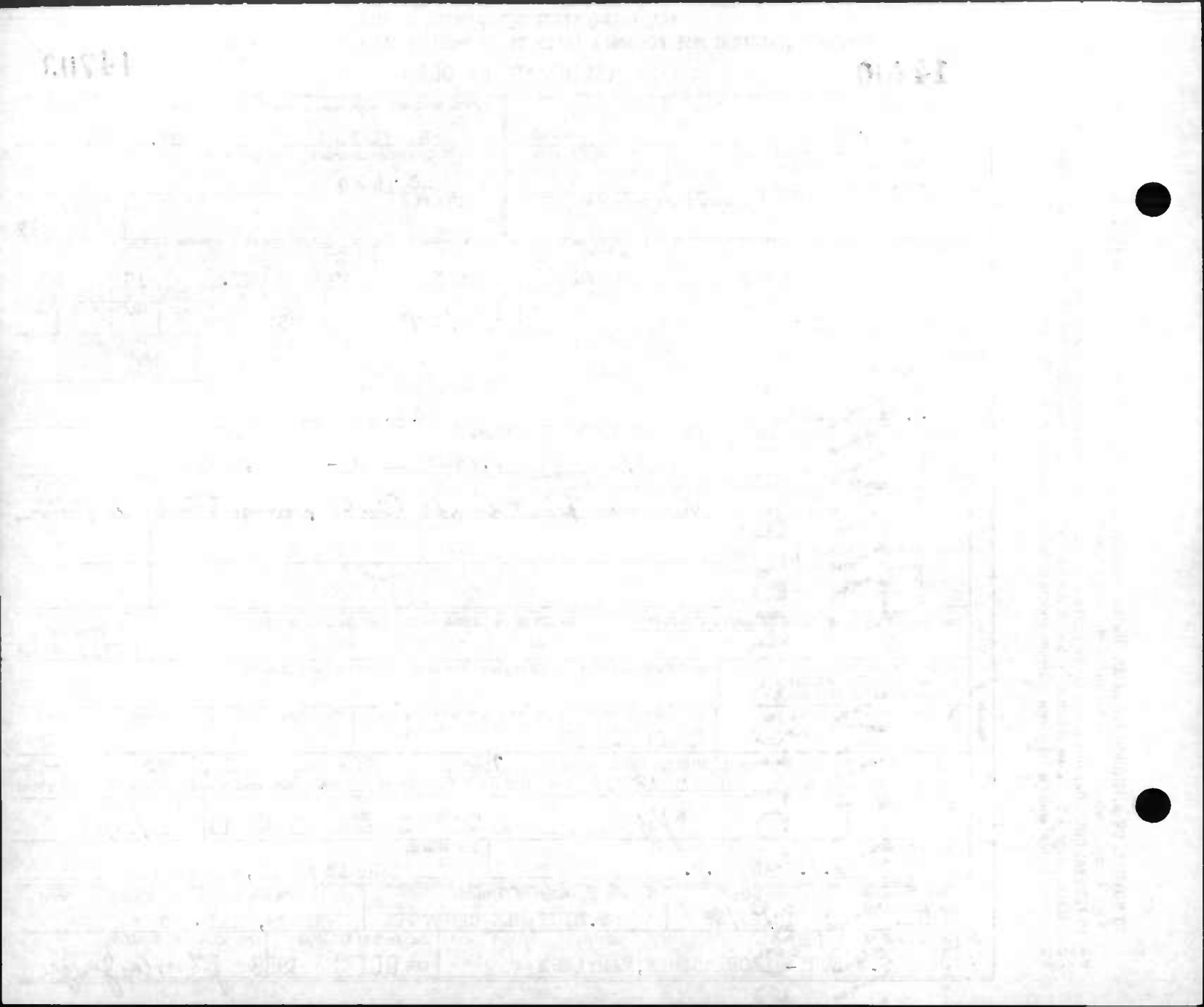
CERTIFICATE OF DEATH

14703

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY ST MARYS MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOTLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOTLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First EUGENIA Middle SMITH Last RALEY | | 4. DATE OF DEATH Month OCT. Day 19 Year 19 66 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/13/1873 |
| 9. AGE (In years last birthday) 93 yrs. | | 10. IF UNDER 1 YEAR Months 18 Days 1 | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME J. FRANK SMITH | | 14. MOTHER'S MAIDEN NAME ALICE DUNBAR | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. N/A | |
| 17. INFORMANT J. FRANK RALEY - RIDGE, MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular heart disease (Aortic regurgitation) 4211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 16 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May , 19 52 , to Oct 19, 1966 , that (I) (we) last saw the deceased alive on Oct 18, 1966 , and that death occurred at 12:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE P.J. BEAN M.D. | | 22b. DATE SIGNED 10/21/66 | |
| 22c. PHYSICIAN'S NAME (Type) P.J. BEAN M.D. | | 22d. ADDRESS GREAT MILLS, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/22/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY | | 23d. LOCATION (City or Town) (County) (State) RIDGE, MARYLAND | |
| 24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR DATE OCT 25 1966 | |
| 25b. REGISTRAR'S SIGNATURE John Charles Judge | | | |

1950

1950



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14701

CERTIFICATE OF DEATH

14704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First DEBARAH Middle H. Last RATLEDGE | | 4. DATE OF DEATH Month OCT. Day 2 Year 1966 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/3/1911 |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK TYPIST | | 10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME LOUIS HERGENRATHER | | 14. MOTHER'S MAIDEN NAME ELIZABETH SHAW | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217 14 3273 | |
| 17. INFORMANT THOMAS F. RATLEDGE - SAME AS #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Ventricular Hypertrophy DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 2, 1957 , to Oct 2, 1966 , that (I) (we) last saw the deceased alive on 2 Oct 1966 , and that death occurred at 2 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ernest D. Rehm | | 22b. DATE SIGNED 10/4/66 | |
| 22c. PHYSICIAN'S NAME (Type) ERNEST REHM M.D. | | 22d. ADDRESS LEONARDTOWN, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/5/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY ST. ANDREWS CEMETERY | | 23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, MARYLAND | |
| 24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE OCT 10 1966 | |

2152-2153

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|------------------|-------------------------------------|---|--|---|--|------------|--|-----------------------------------|---|---------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 14702 | | | | | 14705 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | |
| a. COUNTY | | St. Mary's | | | a. STATE | | b. COUNTY | | | | |
| | | MARYLAND | | | Maryland | | St. Mary's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| Leonardtwn | | 2 hrs. 15 Min | | | Rural Compton | | 18-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? | | | |
| St. Mary's Hospital | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year | |
| Charles | | Purnell | | Somerville | October | | 15 | 19 | 66 | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> | NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | | Months | Days | Hours | Min. |
| Male | Negro | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | October 15, 1966 | yrs. | | | | | 2 | 15 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Infant | | | | | | St. Mary's Co. Maryland | | America | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| Charles Lloyd Johnson | | | | | Mary Estelle Somerville | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| | | | | | | Mother | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY | | Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| Hour a.m. p.m. | | 19 | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/15/1966</u> to <u>10/15/1966</u> , that (I) (we) last saw the deceased alive on <u>10/15/1966</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | 22b. DATE SIGNED | | | | | |
| S. Laurel, M.D. | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | |
| Santiago Laurel, M.D. | | | | | | Box 328 Leonardtown, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) | | | (State) |
| BURIAL | | | 10/18/66 | | ST. ALOYSIUS | | | LEONARDTOWN | | | MD. |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| W. CLARKE MATTINGLEY | | | | | | LEONARDTOWN, MD. | | | DATE OCT 21 1966 J. Charles Judge | | |

14708

14708

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which may be related to land management or surveying.]

DATE: [illegible]
BY: [illegible]
[Additional faint text at the bottom of the page, possibly a signature or distribution list.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14703

CERTIFICATE OF DEATH

14706

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL <u>Lexington Park</u> <u>18/</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u> | | d. STREET ADDRESS <u>Rt 2 Box 46</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Albert</u> Last <u>Thomas</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>19 66</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 11, 1883</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>George E. Thomas</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mattilda Carroll</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>219-16-1552</u> | |
| 16. SOCIAL SECURITY NO. <u>219-16-1552</u> | | 17. INFORMANT <u>Theresa A. Thomas</u> Address <u>same as # 2 above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 30, 1966</u> to <u>Oct 3, 1966</u> that (I) (we) last saw the deceased alive on <u>Oct 3</u> 19 <u>66</u> and that death occurred at <u>7 A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W.H. Patrick</u> | | 22b. DATE SIGNED <u>10-</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>William H. Patrick MD</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>10/6/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Face</u> | 23d. LOCATION (City or Town) (County) (State) <u>Great Mills Md</u> |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14704

CERTIFICATE OF DEATH

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| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u> | | | c. LENGTH OF STAY IN lb <u>24 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Erwin</u> Middle <u>Robert</u> Last <u>Wehrmann</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1966</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 13, 1896</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>Robert Wehrmann</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Grafe</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW I</u> <u>Navy</u> | | | |
| 16. SOCIAL SECURITY NO. <u>350-10-3975</u> | | | | 17. INFORMANT <u>Mrs Louise Wehrmann</u> Address <u>same as # 2 above</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Dilatation of Heart</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular Disease</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>66</u> , to <u>Oct 11</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Oct 11</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Charles Greenwell</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles Greenwell M. D.</u> | | | | 22d. ADDRESS <u>Leonardtown, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 14, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Leonardtown, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u> | | | | ADDRESS <u>Leonardtown, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 14 1966</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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